childhood hypertension over 20 years ago. Furthermore, the sounds produced during auscultatory blood pressure measurement are heard better with the bell side.

However, sometimes the solution of one problem creates another. With little or no pressure on the bell side, there frequently is some space left between the arm surface and the stethoscope because of the irregularity of the arm surface. Consequently, the sounds are either very faint or not audible at all. Use of the diaphragm side eliminates this problem and I am now using the diaphragm side.

Dr Meth's suggestion that a study be made comparing the bell versus the diaphragm with light pressure is a pertinent one. I have tested this a few times and have found the same lowering effect on the diastolic reading when firm pressure is applied to the diaphragm side. This needs documentation with measured amounts of pressure.

SOL LONDE, MD
Department of Pediatrics
UCLA School of Medicine
Los Angeles, CA 90024

Medicare's Future

TO THE EDITOR: It was with dismay that I read your editorial entitled "Medicare—Progressively Overburdened and Underfunded" in the September 1984 issue.[1]

Your reference to Victor Fuchs's observations were both interesting and relevant to the discussion of Medicare's future. Fuchs observed that in 1935 "when the age of eligibility for social security retirement benefits was set at 65, life expectancy at age 65 was about what it is now at age 72."

Unfortunately, your editorial's ensuing support for a redefinition of old age and Medicare eligibility to age 72 overlooked several critical issues:

- In today's society, there is a tendency for people to retire earlier, making it far more difficult for the aged to pay the high cost of adequate health care. And, let us not forget that with today's retirement also comes a loss of costly private health insurance.
- Rolling Medicare eligibility back to age 72 would extract a terrible price in human suffering for those unable to pay the price of needed health care.

While an eligibility roll-back may keep Medicare solvent, it would not preserve the intent of the 1965 legislation, nor solve the underlying problems Medicare was established to address. Your references to an "emotional hue and cry" and to "special-interest groups" in speaking of the opposition to a proposed roll-back serve only to cloud these underlying issues.

BARRY A. COOPER
4955 Paseo Segovia
Irvine, CA 92715

REFERENCE

1. Watts MSM: Medicare—Progressively overburdened and underfunded (Editorial). West J Med 1984 Sep; 141:372-373

More on Pains Cured by Examination

TO THE EDITOR: Recent discussions with colleagues concerning cure of pelvic and abdominal pain through pelvic examination[1,2] have elicited another hypothesis and an intriguing case history.

The hypothesis is that partial torsion of a relatively mobile structure, such as sigmoid colon or ovary, might underlie some cases, and might be relieved after the simple manipulation inherent in examination.

The case concerns a 44-year-old internist, previously and afterwards healthy, in whom sudden, severe and unremitting right lower quadrant pain developed, which radiated to groin and vulva. Upon light abdominal palpation by a colleague, the pain remitted abruptly; urinary urgency followed, with painless passage of a stone. The apparent mechanism of pain relief was migration of a urolith, probably ureteral. The timing suggests a relationship between the events; however, the deep retroperitoneal location of the ureter should prevent effective transmission of surface pressures, especially slight ones, and alternative explanations (unrelated events, or events related by unknown means) cannot be dismissed. If several other cases were reported, the entity of "examination-assisted stone migration" might be established no matter how obscure its mechanism.

HENRY SCHNEIDERMAN, MD
Teaching and Research Scholar,
American College of Physicians
Assistant Professor of Pathology
Assistant Professor of Medicine
JANICE WILLMS, MD
Assistant Professor of Medicine
Director, Physical Diagnosis Course
University of Connecticut Health Center
Farmington, CT 06032

REFERENCES

1. Sargent E: Unusual pelvic pain apparently cured by pelvic examination (Correspondence). West J Med 1980 Jul; 133:80
2. Schneiderman H: Pelvic pain cured by pelvic examination (Correspondence). West J Med 1984 Nov; 141: 686

Preoperative Evaluations

TO THE EDITOR: Levinson's report in the September issue[1] on the value of preoperative evaluations by an internist does not suggest, as Abrams concludes in the accompanying editorial, "a well-founded basis for the routine preoperative evaluation for patients undergoing eye surgery in a general community hospital."[1,2] In fact, the study is fundamentally flawed and unable to support any important conclusions regarding the question at hand.

First, whether a patient received a preoperative visit by an internist "was determined by the ophthalmologist." Consultations were performed on 258 patients, but we are told nothing specific about the cases for which consultation was not requested. Without at least minimal information regarding this group, one cannot possibly justify any conclusions regarding the value of *routine* preoperative evaluations.

Second, the benefit is questionable even in the selected patients who received a preoperative evaluation. We are told that 51/258 patients had "conditions considered important to surgical risk," but the literature cited to justify these conditions as risk factors is derived mostly from studies of patients undergoing general anesthesia for general surgery. The relevance of these supposed risks to ophthalmological surgery is unclear, especially since eye patients commonly receive only local anesthesia and mild sedation during their operations. Further, assignment of risk factors to individual patients was apparently subjective in many instances. For example, 26/59 risk factors cited were "severe chronic lung disease" or "severe asthma." No objective data are presented to justify the assessment of severity in these patients; the internists' impressions are simply taken at face value.

Even if we grant that many true risk factors were discovered, was this of any benefit to the patients? Only five actual